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Health Care Financing Administration

MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING GUIDE

DRAFT

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I. INTRODUCTION

The purpose of this Medicaid School-Based Administrative Claiming Guide (referred to hereafter as the Guide) is to provide information for schools, State Medicaid Agencies, the Health Care Financing Administration (HCFA) staff, and other interested parties on the existing requirements for claiming Federal funds under the Medicaid program for the costs of administrative activities, such as Medicaid outreach, that are performed in the school setting. This guide is not intended to supersede guidance on requirements for the provision in the school setting of medical assistance; that is, medical services, such as may be provided in school-based health clinics (SBHCs). Furthermore, this guide does not supersede any statutory or regulatory requirements, and is subject to any subsequent policy issuance or clarifications. For purposes of the Guide, a "school-based health services program" refers to any type of Medicaid-covered health service provided in a school-based setting.

As noted throughout this Guide, Federal Medicaid requirements provide only a framework for State Medicaid Programs. Since each State establishes and administers its Medicaid program within this framework, Medicaid programs vary considerably from State to State, and within each State over time. States have considerable flexibility to:

1) establish eligibility standards;

2) determine the provider of and the type, amount, duration, and scope of services;

3) set the rate of payment for services; and

4) administer its own program, including development of administrative requirements to verify claims.

The school setting offers unique advantages and opportunities to reach children and families to inform and encourage them to enroll in the Medicaid program as well as to provide assistance to students in accessing medical services. The Health Care Financing Administration (HCFA) recognizes that certain members of a school staff may spend a significant amount of time on such activities for its students. When administrative activities are "found necessary by the Secretary for the proper and efficient administration of the State plan" and the students are Medicaid-eligible or potentially eligible for Medicaid (if the activity is Medicaid eligibility outreach), Federal Financial Participation (FFP) may be available. While Federal Medicaid requirements are administered by HCFA, to determine specific State Medicaid program requirements, schools should contact their State Medicaid Agency.

This Guide provides the basic Federal requirements for administrative claiming in the Medicaid program and is intended to foster better understanding of program parameters and the applicable statutory and regulatory provisions. The Guide is not intended to provide new policy; rather, it is intended to consolidate and clarify existing policy. This Guide lists the relevant legal and programmatic bases and authorities, including sections of the Social Security Act, Parts 42 and 45 of the Code of Federal Regulations (CFR), and the Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments." In addition, OMB mandated in Circular A-87 that the Department of Health and Human Services (DHHS) issue implementing material for Circular A-87 on behalf of the Federal government. The resulting document issued by DHHS, ASMB C-10, is intended to assist State, local, and Indian tribal governments in applying OMB Circular A-87. The Guide also references HCFA policy issuances, such as the Medicaid and School Health: A Technical Assistance Guide, issued in 1997.

HCFA envisions this Guide will be useful for schools or school districts, State Medicaid Agencies, and HCFA staff in the process of development, review, approval, and implementation of programs involving school-based services. Since HCFA is responsible for assessing these programs in accordance with the Federal Medicaid requirements, States' programs for Medicaid administrative claiming for school-based activities will be formally reviewed and approved by HCFA prior to implementation. States may realize after reading this Guide that some of what they are or have been claiming as administrative costs is unallowable, and in those cases HCFA will work with the State(s) to develop acceptable administrative claiming procedures.

II. BASIS/AUTHORITY

The following sections provide selected statutory, regulatory and other Federal Government references/authorities applicable to claiming Federal funding under the Medicaid program for the costs of school-based administrative activities.

A. Statute/Regulations

- Proper and efficient methods of administration: section 1903(a)(7) of the Social Security Act (the Act)
- Federal matching rate for administration: section 1903(a)(7) of the Act
- Timely filing: section 1132 of the Act, Title 45 of the Code of Federal Regulations (CFR) Subpart A 95.1 ff
- Skilled Professional Medical Personnel (SPMP): section 1903(a)(2)(A) of the Act, 42 CFR 432.50
- Family Planning: section 1903(a)(5) of the Act, 42 CFR 433.15(b)(2), 432.50(b)(5)
- Regulatory citations related to documentation:

42 CFR	Description

430.1	Scope of subchapter C - Proper and efficient administration
431.1(d)	Agreement with Federal or State agencies
430.12	Submittal of State plans and plan amendments
430.30(b)	Grants procedures - Program estimates (HCFA-37)
430.30(c)	Grants procedures - Expenditure reports (HCFA-64)
430.32	Program reviews
430.33	Audits - OIG audits including cost efficiency
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433.53	State plan requirements - for State funds

45 CFR	
Part 95	Subpart A - Time Limits for States to File Claims
Part 95	Subpart E - Cost Allocation Plans

B. OMB Circular A-87

The OMB Circular A-87 establishes cost principles and standards for determining costs for Federal awards carried out through grants, cost reimbursement contracts, and other agreements with State and local governments and Federally recognized Indian tribal governments (governmental units).

III. INTERAGENCY AGREEMENTS

A. General

In order to claim Federal matching for the costs of Medicaid administrative activities performed in schools, the State Medicaid Agency must have an interagency agreement with the State Department of Education or separate agreements with participating school districts in accordance with regulations at CFR 431.10(d). Such interagency agreements serve to describe and define the relationship between the State Medicaid Agency, the entities for which claims will be made, and the responsibilities of each party to the agreements. While the State Medicaid Agency is the only

entity that may submit claims to HCFA for reimbursement, every entity that is generating administrative claims needs to be covered by an interagency agreement.

The requirement that every entity submitting claims must be covered under an interagency agreement does not necessarily require their parent agency to be party to the agreement. For example, schools and/or school districts which will be submitting claims directly to the State Medicaid Agency would need to enter into an interagency agreement with the State Medicaid Agency. However, the State Department of Education may not need to be party to the agreement, if they have no involvement or responsibilities related to the claims or activities. An individual school may not need to be party to the interagency agreement if its employees are all part of the school district or county, and such school district/county itself is party to the agreement directly with the State Medicaid Agency. These interagency agreements should list the allowable administrative activities for which school districts will be reimbursed and specify that all claims will be in accordance with OMB Circular A-87, the State Medicaid Plan and all Federally approved public assistance cost allocation plans. The administrative activities must be directly related to the administration of the State's Title XIX Plans for FFP to be available.

B. Requirements

Any local education agency (LEA) or school that receives payments for administrative activities under Medicaid may be acting as an agent or contractor for the State Medicaid Agency. To claim Federal funding for allowable administrative activities, there must be a formal intergovernmental/interagency agreement between the LEAs or schools and the State Medicaid Agency. While prior approval by HCFA of the interagency agreement is not required, HCFA is required to and will review claims pursuant to that agreement to determine their allowability for Federal matching funds. Therefore, HCFA strongly encourages that States consult with HCFA as early as possible in the development of their school-based administrative claiming programs and the associated interagency agreements, and prior to the submission of claims for Federal matching to HCFA, to ensure that claims are in accordance with Federal requirement and can be paid without delay.

The interagency agreements must include:

- the mutual objectives and responsibilities of all parties to the agreement;
- the activities or services each party offers and under what circumstances;
- the specific activity codes (by reference or inclusion) approved by HCFA for administrative costs that will be claimed;
- the specific description and methodology (by reference or inclusion) approved by HCFA for building the claim for administrative costs;

- the cooperative and collaborative relationships at the State and local levels; and

- the methods for payment or reimbursement, exchange of reports and documentation, and continuous liaison between the parties, including designation of State and local liaison staff.

IV. CONSTRUCTING TIME ACTIVITY CODES

A. General

School or school district employees may engage in activities which involve furnishing direct services and/or the performance of other administrative activities required and covered by education programs, other social programs, and the Medicaid program. Some or all of the costs of these services and administrative activities may be claimed under these programs; however, an appropriate claiming mechanism must be used. The primary mechanism for identifying and categorizing activities performed by the school or school district employees, and for developing claims for the costs of these administrative activities that may be properly reimbursed under these programs, is the time study. Because employees work on multiple activities and cost objectives, OMB Circular A-87 permits the use of "substitute systems" for allocating salaries and wages to Medicaid in place of an activity report. Any substitute mechanism must be approved by HCFA.

It is essential to develop the elements of the time study, including activity codes, with recognition and consideration of the actual functions and responsibilities being performed by the school or school district employees, the requirements of the programs, and in accordance with principles that appropriately distinguish between and account for all these factors. Section IV, subsection B of the Guide discusses the principles for developing the elements of the time study mechanism, the activity codes. Subsection C provides standard activity codes developed in accordance with these principles. These codes may be used by States, school districts, and schools as the basis for time studies which would be used to allocate administrative costs for purposes of making claims under the Medicaid program.

B. Operational Principles

1. Proper and Efficient Administration

According to section 1903(a)(7) of the Act and the implementing regulations at 42 CFR 430.1 and 42 CFR 431.15, for the cost of any activities to be allowable and reimbursable under Medicaid, the activities must be "found necessary by the Secretary for the proper and efficient administration of the plan" (referring to the Medicaid State plan). Additionally, OMB Circular A-87, which contains the cost principles for State, Local and Indian Tribal Governments for the administration of Federal awards, provides that "Governmental units are responsible for the efficient and effective administration of Federal awards." Therefore, this principle is applicable

for other Federal government programs in addition to the Medicaid program. Under these provisions, costs must be reasonable and necessary for the operation of the governmental unit for the performance of the Federal award.

The principle of proper and efficient administration must be applied in developing time study activity codes. For example, outreach activities would be considered to be in support of the Medicaid program if they were in regard to explaining Medicaid requirements. By contrast, outreach with respect to explaining the requirements of education program requirements would not be in support of the Medicaid program and must be separately accounted for.

2. Claiming for Allowable Activities Only

Medicaid does not pay for administrative expenditures related to, or in support of, services that are not included in the State Medicaid plan or services which are not reimbursed under Medicaid. For example, where school employees assist a Medicaid-eligible child to obtain medical services that are included in the child's Individualized Education Plan (IEP), if the provider furnishing such services is not participating in the State's Medicaid program or is not part of a managed care organization (MCO) participating in the State's Medicaid program, FFP would not be available for the services; furthermore, FFP would not be available for the administrative activities to assist the child in accessing such services. These activities would be not be claimable because they would not be considered in support of the operation of the Medicaid State plan (even if the services are included in the State's Medicaid program).

In addition, Medicaid does not pay for health care services that are rendered free of charge to the general population. Consequently, any administrative activity which supports the referral, coordination, planning of screens or services that are provided free to the general population would not be considered as Medicaid administration. This type of activity is subject to the free care principle, discussed in Section V.J.

Note, as required by Medicaid statute, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services must be offered to a child whether or not a State has included such services in its State Medicaid plan. Administrative expenditures related to, or in support of, EPSDT are reimbursable under Medicaid, so long as the providers who furnish such services participate in the Medicaid program.

3. Capture 100 Percent of Time

In order to ascertain the portion of time and activities that are related to administering the Medicaid program, States must develop an allocation methodology that is approved by DHHS. The approved allocation methodology, which may use random moment sampling (RMS), contemporaneous time sheets, or other quantifiable measures of employee effort, is often referred to as a time study. The time study must incorporate a comprehensive, all-inclusive list of the activities performed by staff whose costs are to be claimed under Medicaid. That is, the time

study must reflect **all** of the time and activities (whether allowable or unallowable) performed by employees participating in the Medicaid administrative claiming program.

In order to ensure that the time study reflects all of the activities performed by the time study participants, HCFA, the State, and the school districts must work together to establish the master list of activities by program. HCFA and the State would then determine which of the activities in each program are allowable Medicaid administrative activities.

HCFA and States determine allowable Medicaid administrative activities in accordance with the following guidelines found in OMB Circular A-87 Attachment B, section 11.h.(5):

> Personnel activity reports or equivalent documentation must meet the following standards:
>
> > (a) They must reflect an after-the-fact distribution [i.e., distribution following completion of the activity] of the actual activity of each employee,
> >
> > (b) They must account for the total activity for which each employee is compensated,
> >
> > (c) They must be prepared at least monthly and must coincide with one or more pay periods, and
> >
> > (d) They must be signed by the employee as being a true statement of activities and the employee/office will retain documentation to support the report.

Note, the requirement to document costs monthly does not mean that time studies must be conducted monthly. ASMB C-10 provides guidance on the circumstances dictating the frequency of time and effort reporting.

If a portion of a sampled employee's time is also billed as medical services, then the administrative time study results should be validated by comparing the time coded to direct medical services (Code 4) to the actual amount of hours billed directly. The results should be within a reasonable tolerance or else the time study may result in an effective double payment.

In order to ensure that all of the time study participants are reflected in the time study, the staff classifications and associated supporting documentation (such as position descriptions) for time study participants should also be reviewed and considered in developing the time study activity codes. This will also ensure that the unique responsibilities and functions performed by the participants, as well as the special factors and programs applicable to the participating schools or school districts are accounted for and included in the time study codes. As these codes are formulated, they should be compared against the staff classifications and supporting position descriptions to ensure that all functions being performed are identified and incorporated into the codes.

4. Parallel Coding Structure: Medicaid and Non-Medicaid Codes for Each Activity

The time study activity codes must be developed to capture all of the activities performed by the time study participants, as indicated by Principle 3., as well as carefully balance and present similar activities in relation to the programs for which they are performed. This is accomplished by developing parallel time study activity codes which reflect the particular activity functions and which clearly distinguish between, and incorporate, the requirements of the various programs as relates to the function. Parallel coding is a method for identifying and categorizing activities which are generally similar, but are also different with respect to specific elements. Developing parallel activity codes for the different programs ensures that all activities are accounted for, and clarifies reporting with respect to similar activities. As noted in Section V.B.4., all staff in the sample universe should be trained on proper coding procedures, including reporting activities under the parallel codes, before sampling begins.

There may be overlap between activities attributable to different programs, and the time study methodology should determine which code is appropriate for reporting purposes. For example, school employees may perform an outreach function for both the education (IDEA) program and the Medicaid program. By establishing two (or even more) activity codes for outreach, time study participants will be able to clearly distinguish and identify the appropriate codes under which to report. Code 1.a. (for non-Medicaid outreach) and Code 1.b. (for Medicaid outreach), discussed in subsection C. below illustrate two parallel activity codes.

5. Duplicate Payments

Duplicate payments are **not** allowable when determining allowable administrative costs under Medicaid. Payments for allowable administrative activities must not duplicate payments that have been or should have been included and paid as part of a rate for services, part of a capitation rate, or through some other local, State or Federal program. Medicaid administrative costs may not be claimed for activities that are integral parts or extensions of services. Furthermore, in no case should a program or claiming unit in a local jurisdiction be reimbursed more than the actual cost of that program or claiming unit, including State, local, and Federal funds. The State must provide assurances to HCFA of non-duplication through their administrative claims and the claiming process to HCFA. The State may dispute HCFA's position on what is a duplicate payment through appeal of any disallowance to the Departmental Appeals Board (DAB).

The Medicaid program should not pay for an activity already paid for or otherwise reimbursable under another mechanism, for example:

- An activity that has been, or will be, paid for as a medical assistance service (or as a service of another (non-Medicaid) program) should not be paid again as a Medicaid administrative cost.

- An activity that has been, or will be, paid for as a Medicaid administrative cost should not be paid again as Medicaid administration.

- An activity that is included as part of a managed care rate and is reimbursed by the managed care organization should not be reimbursed again through a claim for Medicaid administration, or through a fee-for-service reimbursement rate.

As appropriate, the mechanism under which managed care rates are set and adjusted should address the activities and services being furnished in the school setting.

6. Coordination of Activities

In addition to avoiding duplicate payments, as indicated in Principle 5., duplication of activities or effort should also be avoided. Under Principle 1., allowable administrative activities must be necessary "for the proper and efficient administration of the [Medicaid] State plan" (emphasis supplied), as well as for the operation of all governmental programs. Therefore, it is important in the design of school-based administrative claiming programs that the local education agency (LEA) or school not perform activities that are already being offered or should be provided by other entities, or through other programs. As appropriate, this requires the close coordination between the LEAs, schools, State Medicaid Agency, State Department of Education, providers, community and non-profit organizations, and other entities related to the activities performed.

The following are examples of activities that should be coordinated:

- Activities performed by a managed care organization (MCO) for the Medicaid or other program enrollees of the MCO, such as case management functions. To avoid duplication of these functions by school personnel, coordination mechanisms should be established between the school and appropriate entities, such as the MCO and State Medicaid Agency.

- Reimbursement rate setting mechanism. As appropriate, the rate setting mechanism under which the rates for functions which are performed by schools, but reimbursed by other entities, may need to reflect such functions. For example, the capitation rate paid to an MCO may include amounts for the performance of functions performed by schools; that is, such functions are the responsibility of the MCO. However, after coordination efforts, such functions may still need to be performed by the schools. In such cases, the MCO reimbursement rates may need to be adjusted to reflect the activities and services being furnished in the school setting.

- An activity that is provided/conducted by another governmental component. For example, it is not necessary for EPSDT educational materials, such as pamphlets and flyers that have already been developed by the State Medicaid Agency, to be

redeveloped by schools. It would be inefficient in the allocation of Medicaid program and school resources to do so. In order to avoid this, school districts/schools should coordinate and consult with the Medicaid State agency to determine the appropriate activities related to EPSDT and to determine the availability of existing materials.

7. Performing Direct Services v. Administrative Activities

Activities performed in the school setting can include the provision of program services, administrative activities, or both. The related programs for which these activities are performed may include education, social, medical (Medicaid), or other programs. Typically there are different funding sources and mechanisms related to each program or type of activity. As a result of these factors, in constructing the time study activity codes under which participating staff will report, it is essential to distinguish between activities that represent the provision of services or administrative functions, and the program for which they are performed. It is also necessary to identify activities that support a service that is a routine action customarily included as part of the payment for a service, such as filling out a billing claim form. The time study methodology should identify the costs of direct medical and other services and ensure that those costs are not included in the claims for administrative activities.

For example, the school or school district may be a participating Medicaid provider. Covered Medicaid services provided by school employees for Medicaid eligible children will be reimbursed through the mechanism for billing services. The time study must identify direct services and ensure that these services are not included in administrative claims. Additionally, certain school employees may be performing Medicaid related outreach activities. Finally, school employees may also be performing educational services or outreach for education programs. The time study codes must distinguish between each of the these activities. Therefore, as indicated in subsection C., Medicaid program outreach would be reported under Code 1.b., the education program outreach under Code 1.a., the Medicaid services under Code 4., and the educational services under Code 3.

As indicated in Principle 5., payments for allowable Medicaid administrative activities must not duplicate payments that have been, or should have been, included as part of a **direct** medical service, capitation rate, or through some other State or Federal program (as specified in OMB Circular A-87). It is the State's responsibility to ensure there is no duplication in a claim prior to the claim's submission to HCFA.

Activities that are considered integral to, or an extension of, the specified covered service are included in the rate set for the direct service. These activities are properly paid for as part of the medical service and reimbursed at the Federal Medical Assistance Percentage (FMAP), and may not be claimed as an additional cost through administrative case management defined below.

Administrative Case Management

While some case management activities may fall within the scope of both administrative and targeted case management, a State may not claim the same costs both as targeted case management and administrative case management at the same time.

The State Medicaid Manual (SMM) Section 4302 identifies certain activities which may be properly claimed as **administrative** case management. An allowable administrative cost must be directly related to a Medicaid State plan or waiver service, and be necessary for the "proper and efficient administration of the State plan."

Some examples of administrative case management services addressed at SMM Section 4302.2 (G)(2), are:

- Medicaid eligibility determinations and redeterminations;
- Medicaid intake processing;
- Medicaid preadmission screening for inpatient care;
- Prior authorization for Medicaid services;
- Utilization review;
- Medicaid outreach.

As indicated in the SMM, HCFA may make determinations regarding other activities as to whether or not they are necessary for the administration of the State plan. More specific examples of these types of activities performed in a school-based setting may be found in the time study activity codes included in this Guide.

Skilled professional medical personnel (SPMP) can perform activities that are either administrative in nature, or which represent the provision of direct medical services (although SPMP cannot provide direct medical services when using the SPMP designation). Therefore, the activity codes should clearly distinguish between SPMP activities that would be reported as an administrative activity and those that, for example, are ancillary to a direct medical service and should be reported as part of the direct service (which would be reimbursed under the services reimbursement rate).

8. Allocable Share of Costs

Since many school-based medical activities are provided to both Medicaid and non-Medicaid eligible students, the costs applicable to these activities must be allocated to both groups. This allocation of costs is sometimes referred to as "discounting" and involves the determination and application of a proportional share of Medicaid students to the total students and the total costs applicable to a specific activity in a particular school or school district. Development of the proportional Medicaid share (also referred to as the Medicaid percentage) should relate to and be based on the claiming unit (the entity submitting the claim). For example, claims may be developed on an individual school basis, a school district wide basis, or a specific unit of

government such as a county.

Through the use of time studies which contain specific activity codes, the cost of school personnel is distributed to certain activities (time study codes) to determine the administrative cost allocable to the Medicaid program. Each code used in the time study must capture the following categories of costs:

(1) **Unallowable** - the activity is unallowable as administration under the Medicaid program,

(2) **100% Medicaid Share** - the activity is solely attributable to the Medicaid program and as such is not subject to the application of the Medicaid share percentage (this is sometimes referred to as "not discounted"),

(3) **Proportional Medicaid Share** - the activity is allowable as administration under the Medicaid program, but the allocable share of costs must be determined by the application of the percentage of the Medicaid eligible population for each school or school district included in the time study, or

(4) **Reallocated Activities** - those activities which are reallocated across other codes based on the percentage of time spent on allowable/unallowable administrative activities.

OMB Circular A-87 states "a cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective **in accordance with relative benefits received"** (emphasis added). To arrive at the Medicaid share percentage, the number of Medicaid eligible students must be determined for each school/school district or governmental unit that is submitting a claim. This number is the numerator in a fraction with the denominator being the total number of students in the same entity. This fractional value is then applied to the total costs applicable to the proportional Medicaid share time codes to determine the costs applicable to Medicaid administrative activities. Note that the number of Medicaid eligibles and the total number of students must be identified for the same time period. For example, total enrollment at the opening of school, compared with Medicaid enrollment in November, may not be used.

$$\text{Medicaid Costs} = \frac{\text{Total Number of Medicaid Students}}{\text{Total Number of Students}} \times \text{Costs to be allocated}$$

The number of Medicaid eligible students must be either obtained from or verified with the State Medicaid Agency. This may be done through a matching of school/school district enrollment data to Medicaid eligibility files.

In the following example, administrative claims are developed on a school district basis. The

purpose of applying a proportional Medicaid share is to determine the amount to be allocated between Medicaid and non-Medicaid students. The following example establishes how much of the costs related to the activity should be allocated to Medicaid. The amount of Federal reimbursement is then determined based on the resulting amount.

EXAMPLE OF MEDICAID SHARE

Gross Claimable Amount = $1,500

Number of Medicaid Students in District = 1,000

Number of Total Students in District = 5,000

Activity = referral, coordination, and monitoring of Medicaid Services (Proportional Medicaid /50 Percent Federal Financial Participation)

Medicaid Share Factor: Number of Medicaid Students/Total Students = 1,000/5,000 = 20 percent

Gross Claimable Amount	$1,500
Medicaid Share Rate X .20	
	$300
FFP Rate	.50
Net Claimable Amount	$**150**

9. Enhanced FFP Rates

a. Skilled Professional Medical Personnel (SPMP) School Administrative Claiming

i. Basis

The following provides the basic statutory and regulatory authorities and guidelines related to SPMPs:

Law:	Section 1903(a)(2) of the Social Security Act
Regulations:	42 CFR 432.2 - Definition of SPMP
	42 CFR 432.50 - FFP rates (personnel)
	42 CFR 433.15 - FFP rates (program).
	SPMP Review Guide (dated June 1986)

ii. SPMP Criteria for Enhanced FFP

Federal Financial Participation (FFP) at the enhanced rate of 75 percent may be available for State claims for expenditures related to the costs of activities performed by individuals in the administration of the Medicaid program if each of the following criteria are met:

(I). The expenditures are for the costs of activities that are directly related to the administration of the Medicaid program, and as such, do not include expenditures for the direct provision of a medical service.

(II). The SPMP has professional education and training in the field of medical care or appropriate medical practice.

(III). The SPMPs have duties and responsibilities that require those professional medical knowledge and skills.

(IV). A State documented employer-employee relationship exists between the State Medicaid Agency and the SPMP and staff directly supporting the SPMP.

(V). The directly supporting staff are secretarial, stenographic, copying personnel, and file and records clerks who provide clerical services that are directly necessary for the completion of the professional medical responsibilities and functions of the SPMP staff. The SPMP must directly supervise the supporting staff and be responsible for the performance of the supporting staff's work.

(VI). The enhanced FFP rate of 75 percent is available for SPMP and directly supporting staff *of other public agencies if* all of the applicable criteria i. through v. are met, and the public agency has a written agreement with the State Medicaid Agency verifying that those requirements are met.

(VII). The costs of activities performed by SPMP and those of directly supporting staff which benefit more than one program must be allocated in accordance with the principles contained in the OMB Circular A-87. FFP under the Medicaid program is available only for the SPMP and related costs which are allocable to the Medicaid program.

Federal regulations contain specific mandates for SPMPs, including the requirement that SPMPs have completed a two year or longer program leading to an academic degree or certificate in a medically related program. State qualification requirements for SPMPs can differ (be more stringent than) from the qualification requirements for participating as a Medicaid provider.

Similarly, State provider qualification standards for a particular service provided in the school setting (such as rehabilitation services described in Federal Medicaid regulations at 42 CFR 440.130(d)) may be less stringent than the provider qualification standards for the same service provided in the community setting. Therefore, individuals who qualify to provide certain services in the school might not qualify as an SPMP, or might not qualify to provide the same services in the community. Similarly, school health aides, counselors, and other staff in the schools may be allowed to provide medical services in the school setting but might not qualify as an SPMP, or might not qualify to provide such services in the community.

There are two basic criteria applied to determine whether school staff qualify as SPMPs:

- State Standards. First, it is necessary to determine the State's standards for provider qualifications, especially where the State Department of Education (DOE) certification may be accepted as well as State Licensure.

- Professional Education and Training. The next step is to determine whether an individual meets the SPMP criteria for "professional education and training." This can be demonstrated by determining whether the provider has a medical license, certificate, or other document issued by a national or State medical licensure organization, or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization. The Medicaid State Agency may have copies of a provider's credentials since it issues provider numbers. If not, credentials may have to be reviewed onsite.

Even if the individual meets the SPMP qualifications, only those administrative activities which require the use of medical expertise are matchable at the enhanced rate of 75 percent. In a school setting, an example of an administrative activity which potentially could be matched at the higher rate is assessing the necessity for and adequacy of medical care and services required by an individual child. If the administrative activity does not require medical expertise to complete, such as making an appointment for the child with another provider, the activity is not matchable at the enhanced SPMP rate. Activities which are an inherent part of a medical service furnished (for example, the development of a treatment plan), or the actual Medicaid covered service provided by the SPMP, would potentially be claimed as a medical service and, accordingly, be matched at the FMAP specific to each State. Activities which are actually parts of medical services are claimable as services, not as Medicaid administration.

Claims for SPMP activities must be supported by documentation which demonstrates that:

(1) the claims activities were performed by individuals with the appropriate qualifications, and

(2) the activities performed required medical training and expertise of the SPMP.

There must be appropriate documentation to support all claims for enhanced FFP. Routinely maintained supporting records -- day logs, case notes, case records, etc. -- are needed to support the claim. The record should contain such basic information as:

- the activity that was completed,
- the provider of the activity,
- the date of the activity,
- the amount of time, and
- the purpose of the activity.

These supporting records must be available when claims are audited. If the records available do not support the payment of the enhanced rate, the claim will be reduced to regular FFP. Checking a box on a time study form is insufficient to support a SPMP claim for it does not allow for verification.

Allowable administrative activity codes are discussed in Section IV.C. below. For the most part these codes indicate that these activities can only be claimed at the regular FFP rate of 50 percent; most administrative activities do not require the skills of an SPMP.

Any State wishing to claim an activity at 75 percent SPMP rate must submit appropriate documentation for HCFA approval in accordance with regulations at CFR 432.50.

b. Claiming for Administration of Family Planning Services

The enhanced family planning matching rate of 90 percent is available only for the "offering, arranging and furnishing" of family planning services (Section 1903 (a)(5), emphasis added). This enhanced rate is available to personnel who administer as well as directly provide certain family planning services and supplies (42 CFR 432.50(b)(5) as referenced by 42 CFR 433.15(b)(2)). This type of administrative activity would be reported under Code 9.b., "Referral, Coordination, and Monitoring of Medicaid Services." Payment for some or all of the costs of family planning services may also be available under Medicaid as a direct service. These costs are not allowable as administrative expenditures and would be reported under time study Code 4., "Direct Medical Services."

10. Provider Participation in the Medicaid Program

With respect to certain administrative activities that support medical services, Federal matching is available only if the medical services are covered and reimbursable under the State's Medicaid plan. That is, in order for FFP under the Medicaid program to be available for the costs of administrative activities which are performed by school staff and which are related to the delivery of medical services (e.g., referral and coordination of medical services), those medical services must be ultimately reimbursable under the plan. In order for the medical services to be reimbursable under the Medicaid State plan the following requirements must be met:

- The medical services must be furnished to a Medicaid eligible individual.

- The medical services must be included in the State's Medicaid State plan or available and required through the EPSDT program.

- The provider must furnish services as a participating provider in the Medicaid program, with a provider agreement and a Medicaid provider identification number, or must furnish such services as a provider for Medicaid enrollees of a Medicaid MCO.

Therefore, the medical services covered under the State's Medicaid plan must be reimbursable under the plan and also must be performed by a Medicaid provider who bills for the covered services. Costs of administrative activities related to medical services performed in the school or community setting and included in the State's Medicaid plan are not available for FFP unless the provider of services is a Medicaid provider who will bill for Medicaid covered services, or is part of an MCO participating in the State's Medicaid program. If the provider is not participating in the Medicaid program (through a provider agreement or as a network provider in a Medicaid MCO), then the services cannot be reimbursed, and the administrative expenditures would not be considered performed in the proper and efficient administration of the Medicaid program.

Examples of this principle are:

Example 1. A school is a Medicaid participating provider and provides and bills for medical services listed in Medicaid eligible children's IEPs and which are covered under the State's Medicaid State plan. Expenditures for school administrative activities related to school children's services billed to Medicaid by community providers are allowable. The activities would be reported under Code 9.b. below, "Referral, Coordination and Monitoring of Medicaid Services."

Example 2. A school is not a Medicaid participating provider and consequently, even though it provides medical services, it does not bill for any direct medical services, including those listed in children's IEPs. In this example, the costs of the administrative activities performed with respect to the medical services would not be allowable under the Medicaid program, and such activities would be reported under Code 9.a. below, "Referral, Coordination and Monitoring of Non-Medicaid Services."

Example 3. Regardless of whether the school is a Medicaid participating provider, the school program refers Medicaid eligible children to Medicaid participating providers in the community. If the school performs administrative activities related to the services which are billed to Medicaid by community providers, the costs of such activities may be allowable under the Medicaid program, and such administrative activities would be reported under Code 9.b. below, "Referral, Coordination and Monitoring of Medicaid Services."

Example 4. Irrespective of whether a school participates in the Medicaid program or not, school children's services referred to community providers that do not participate in Medicaid are not billed to Medicaid. In this case, the costs of administrative activities related to medical services would not be allowable under Medicaid. These activities would be reported under Code 9.a. below, "Referral, Coordination and Monitoring of Non-Medicaid Services."

Care must be taken in the definition of both the medical services provided and administrative activities performed to ensure that no claim is made for administrative functions performed by a school which are related to services rendered by a provider not participating in Medicaid.

11. Individualized Education Program (IEP) Activities

Under Part B of the Individuals with Disabilities Education Act (IDEA), States may receive grants from the Federal Department of Education (DOE) for the purpose of assisting them in providing special education and related services to children with disabilities. IDEA provisions require school staff to perform a number of education related activities which can generally be characterized as child find, evaluation (initial) and reevaluation, and development of an Individualized Education Program (IEP). For purposes of the Medicaid program, these IDEA/IEP related activities are considered to be education program related activities; that is, in determining whether the costs of such activities are allowable under the Medicaid program, in general, they would not be considered necessary for the proper and efficient administration of the Medicaid State plan. In developing and reporting under time study activity codes, these education related activities must be clearly identified and distinguished; in general, they could be reported under time study Codes 1.a., 2.a., and 3.

However, as noted in the 1997 technical assistance guide, if medical evaluations or assessments are conducted to determine a child's health-related needs for purposes of the IEP development, payment for some or all of the costs may be available under Medicaid as a direct service. These costs are not allowable as administrative expenditures and would be reported under time study Code 4. And if the evaluations or assessments are for educational purposes, Medicaid reimbursement is not available.

Various education-related statutes obligate schools to furnish or make payment for services provided in the school setting for which Medicaid payment is not available. While there are exceptions set forth in section 1903(c) of the Social Security Act. With respect to Parts B and C of IDEA, no other education-related statutes obligate Medicaid payment. For example, Section 504 of the Rehabilitation Act of 1973 requires local school districts to provide or pay for certain services to make education accessible to handicapped children; these services are described in an Individualized Service Plan (ISP). The 1903(c) exception does not include ISP services, and therefore, to the extent a local school district is obligated to furnish or make payment for such services, no Medicaid payment is available.

The IEP/IDEA related activities conducted by school staff, are briefly described below:

- "Child Find." All children with disabilities residing in the State who are in need of special education and related services must be identified, located, and evaluated.

- "Initial Evaluation/Reevaluation." Before special education and related services are provided, an initial evaluation must be conducted by the State educational agency, another State agency or LEA in order to determine whether a child has a disability, and their special/specific educational needs. A re-evaluation would be a determination as to whether the child continues to be disabled, and for the continuing educational needs of the child. Reevaluations must be done at least once every 3 years.

- "Individualized Education Program (IEP)." For children identified and determined to be disabled in accordance with IDEA requirements, an IEP must be developed by an IEP team. The IEP team can include the parents of the disabled child, the regular education teacher, a special education teacher, a representative of the LEA, an individual who can interpret instructional implications of evaluation results, other individuals with special knowledge or expertise, and whenever possible the child.

  The IEP is a written statement for each child with a disability that includes:

  - a statement of the child's present levels of educational performance

  - a statement of measurable annual goals, including benchmarks or short term objectives

  - a statement of the special education and related services and supplementary aids and services to be provided to the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel that will be provided for the child

  - an explanation of the extent, if any, to which the child will not participate with nondisabled children in the regular class and in the activities described above

  - the projected date for the beginning of services and modifications and the anticipated frequency, location, and duration of services and modifications

  - for children age 14 and above, a statement of transition service needs

  - a statement of the child's progress toward annual goals and how the child's parents will be informed of the progress toward the annual goals

The related activities listed above are for the pupose of fulfilling education related mandates under

education statutes (e.g., IDEA); as such, the associated costs of these activities are not allowable as administrative costs under the Medicaid program.

12. Review and Approval of Programs and Codes by HCFA

Although prior approval by HCFA of the administrative claiming programs and codes is not explicitly required in Medicaid statute and regulations, there is implicit authority for HCFA to do so. Specifically, HCFA is required to and will review claims made by State Medicaid Agencies, particularly in situations of the establishment of a new program such as a school-based administrative claiming program, in order to determine the allowability of such claims for Federal matching funds. Furthermore, as discussed below and in section V.D. on Cost Allocation, the Division of Cost Allocation in DHHS (in coordination and consultation with HCFA) is required to approve public assistance cost allocation plans that must incorporate, by reference, the time study and cost allocation methodology adopted by the State Medicaid Agency for schools to develop and document claims submitted to the States. States are required to submit amendments to cost allocation plans and have them approved before they begin operating under them. Therefore, States should consult with HCFA as early as possible in the development of their school-based administrative claiming programs in order to have such programs and the associated time study codes reviewed and approved by HCFA prior to submission for Federal matching to HCFA and prior to submitting their CAP amendments to DCA. This will help ensure that such amendments are approved on a timely basis and that subsequent claims are in accordance with Federal requirements.

Federal regulations (42 CFR 433.34) require that under the Medicaid State plan, the single State agency have an approved public assistance cost allocation plan on file with the Federal Department of Health and Human Services (DHHS) that meets certain regulatory requirements (Subpart E of 45 CFR part 95). As indicated in OMB Circular A-87, Attachment D, a State's public assistance cost allocation plan (CAP) is an official document which describes the grouping and allocation of administrative costs to Federal awards performed by the State under such programs as TANF, Medicaid, Food Stamps, Child Support Enforcement, adoption assistance, and Foster Care and Social Service Block Grant.

Furthermore, there are certain items that must be in the public assistance CAP which a State Medicaid Agency must submit **before** providing reimbursement to school districts for administrative claiming, if it chooses to use schools to provide such services. The public assistance CAP must make explicit reference to the methodologies, claiming mechanisms, interagency agreements, and other relevant issues that will be used by the LEAs, school districts, and schools for making such claims and appropriately allocating costs. Depending on the nature of the referenced time study and costing methodology, they may have to be amended to comply with documentation requirements. States should consult with the HCFA Regional Office in the development of time study and allocation methodologies used for their school-based administrative claiming programs.

The required elements of public assistance CAPs are further discussed in the Cost Allocation section of the Guide (Section V.D.), as is the review and approval process for such plans.

C. Activity Codes: Descriptions and Examples

1. Introduction

When staff perform duties related to the proper administration of the State's Medicaid program, Federal funds may be drawn as reimbursement for the costs of providing these administrative services. To identify the cost of providing these services, a time study of staff, or an acceptable substitute system, must be conducted. The time study identifies the time and subsequent costs spent on Medicaid administrative activities that are allowable and reimbursable under the Medicaid program. The following is a suggested coding scheme. It may not reflect all the activities undertaken by an LEA.

Staff Activity and Codes - the indicators below, which follow each Code, provide the application of the Federal Financial Participation (FFP) rate, the allowability or non-allowability designation, and the proportional Medicaid share status of the Code. In order to maintain coding objectivity by time study participants, time study sheets used by employees should not include references to rates of FFP, proportional or total Medicaid, or whether such codes are allowable, or unallowable under Medicaid. This listing of activity codes should be modified when activities listed as allowable duplicate activities are considered a part of a service per the State's Medicaid plan. See Section IV.B.7. on duplicate payments.

Application of FFP rate

50 percent — Refers to an activity which is allowable as administration under the Medicaid program and claimable at the 50 percent non-enhanced FFP rate.

75 percent — Refers to an activity meeting the requirements of 42 CFR 432.50 for Skilled Professional Medical Personnel (SPMP) and their directly supporting staff which is allowable as administration under Medicaid and claimable at the 75 percent enhanced FFP rate.

Unallowable Activities

U — Refers to an activity which is unallowable as administration under the Medicaid program. This is regardless of whether or not the population served includes Medicaid eligible individuals.

Application of Medicaid Share

TM (Total Medicaid) Refers to an activity which is 100 percent allowable as administration under the Medicaid program.

PM (Proportional Medicaid) Refers to an activity which is allowable as administration under the Medicaid program, but for which the allocable share of costs must be determined by the application of the proportional Medicaid share (the Medicaid percentage). The Medicaid share is determined as the ratio of Medicaid eligible students to total students.

Reallocated Activities

R Refers to those general administrative activities performed by time study participants which must be reallocated across the other activity codes on a pro rata basis. These reallocated activities are reported under Code 10, General Administration. Note that certain functions, such as payroll, maintaining inventories, developing budgets, executive direction, etc., are considered overhead and, therefore, are only allowable through the application of an approved indirect cost rate.

Staff should document time spent on each of the following coded activities:

CODE 1.a. Non-Medicaid Outreach - U
CODE 1.b. Medicaid Outreach - TM/50 Percent FFP
CODE 2.a. Facilitating Application for Non-Medicaid Programs - U
CODE 2.b. Facilitating Medicaid Eligibility Determination-TM/ 50 Percent FFP
CODE 3. School Related and Educational Activities - U
CODE 4. Direct Medical Services - U
CODE 5.a. Transportation for Non-Medicaid Services - U
CODE 5.b. Transportation-Related Activities in Support of Medicaid Covered Services - PM/50 Percent FFP
CODE 6.a. Non-Medicaid Translation - U
CODE 6.b. Translation Related to Medicaid Services - PM/50 Percent FFP
CODE 7.a. Program Planning , Policy Development, and Interagency Coordination Related to Non-Medical Services - U
CODE 7.b. Program Planning , Policy Development, and Interagency Coordination Related to Medical Services -PM/50 Percent FFP
CODE 8.a. Non-Medicaid Training - U
CODE 8.b. Medicaid Specific Training - PM/50 Percent FFP
CODE 9.a. Referral, Coordination, and Monitoring of Non-Medicaid Services - U
CODE 9.b. Referral, Coordination, and Monitoring of Medicaid Services - PM/50 Percent FFP
CODE 10. General Administration - R

The following activity codes represent a generic set of activity categories including administrative and direct services that may be used and adapted to reflect the State's specific program titles, etc. These codes were developed in accordance with the principles discussed in other sections and are therefore recommended for state usage. States may, however, modify and/or amend these codes to reflect their unique situation and other codes or examples may be added to the categories, as long as such changes are made in accordance with the principles set forth in this Guide.

CODE 1.a. NON-MEDICAID OUTREACH - U

This code should be used by all school staff when performing activities that inform eligible or potentially eligible individuals about non-Medicaid social, vocational and educational programs (including special education) and how to access them; describing the range of benefits covered under these non-Medicaid social, vocational and educational programs and how to obtain them. Both written and oral methods may be used. Include related paperwork, clerical activities or staff travel required to perform these activities.

- Informing families about wellness programs and how to access these programs.
- Scheduling and promoting activities which educate individuals about the benefits of healthy life-styles and practices.
- Conducting general health education programs or campaigns addressed to the general population.
- Conducting outreach campaigns directed toward encouraging persons to access social, educational, legal or other services not covered by Medicaid.
- Assisting in early identification of children with special medical/mental health needs through various child find activities.
- Outreach activities in support of programs which are 100 percent funded by State general revenue.

CODE 1.b. MEDICAID OUTREACH - TM/50 percent FFP

This code should be used by school staff when performing activities that inform eligible or potentially eligible individuals about Medicaid and how to access it. Activities would include bringing potential eligibles into the Medicaid system for the purpose of determining eligibility and arranging for the provision of Medicaid services. LEAs may only conduct outreach for the populations served by their school districts, i.e., students and their parents or guardians.

The following are examples of activities that are considered Medicaid outreach:

- Informing Medicaid eligible and potential Medicaid eligible children and families about the benefits and availability of services provided by Medicaid (including preventive, treatment, and screening) including services provided through the EPSDT program.

- Informing children and their families on how to effectively access, use, and maintain participation in all health resources under the Federal Medicaid Program.

- Assisting in early identification of children who could benefit from the health services provided by Medicaid as part of a Medicaid outreach campaign. This activity is distinguished from "child find" activities that are required under IDEA. Child find activities should be reported under Code 1.a. (Non-Medicaid Outreach).

- Informing children and their families on how to effectively use and maintain participation in all health resources under the Federal Medicaid program.

- Contacting pregnant and parenting teenagers about the availability of Medicaid prenatal, and well baby care programs and services.

- Conducting a family planning health education outreach program or campaign if it is targeted specifically to family planning Medicaid services that are covered in the State and offered to Medicaid eligible individuals.

- Providing referral assistance to families where Medicaid services can be provided.

- Notifying families of EPSDT program initiatives, such as screenings conducted at a school site. (Note: This type of activity is subject to the free care principle, discussed in Section V.J.)

- Providing information regarding Medicaid managed care programs and health plans to individuals and families and how to access that system.

Activities which are not considered Medicaid outreach under any circumstances are: (1) General preventive health education programs or campaigns addressed to life-style changes in the general population (e.g., dental prevention, anti-smoking, alcohol reduction, etc.) are not Medicaid outreach activities and (2) Outreach campaigns directed toward encouraging persons to access social, educational, legal or other services not covered by Medicaid.

CODE 2.a. FACILITATING APPLICATION FOR NON-MEDICAID PROGRAMS - U

This code should be used by school staff when informing an individual or family about programs such as TANF, Food Stamps, WIC, day care, legal aid, and other social or educational programs and referring them to the appropriate agency to make application.

- Explaining the eligibility process for non-Medicaid programs.
- Assisting the individual or family collect/gather information and documents for the non-Medicaid program application.
- Assisting the individual or family in completing the application, including necessary translation activities.
- Developing and verifying initial and continuing eligibility for the Free and Reduced Lunch Program. When a school district employee is verifying a student's eligibility or continuing eligibility for Medicaid for the purpose of developing, ascertaining or continuing eligibility under the Free and Reduced Lunch program, report that activity under this code.
- Providing necessary forms and packaging all forms in preparation for the NON-Medicaid eligibility determination.

CODE 2.b. FACILITATING MEDICAID ELIGIBILITY DETERMINATION -TM/50 percent FFP

School staff should use this code when assisting an individual in becoming eligible for Medicaid. Include related paperwork, clerical activities, or staff travel required to perform these activities. This activity does not include the actual determination of Medicaid eligibility.

- Verifying an individual's current Medicaid eligibility status.
- Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
- Assisting individuals or families to complete a Medicaid eligibility application.
- Gathering information related to the application and eligibility determination for an individual, including resource information and third party liability (TPL) information, as a prelude to submitting a formal Medicaid application.
- Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.

- Referring an individual or family to the local Assistance Office to make application for Medicaid benefits.

- Assisting the individual or family in collecting/gathering required information and documents for the Medicaid application.

- Participating as a Medicaid eligibility outreach outstation, but does not include determining eligibility.

CODE 3. SCHOOL RELATED AND EDUCATIONAL ACTIVITIES - U

This code should be used for any other school-related activities that are not health related, such as social services, educational services, and teaching services; employment and job training. These activities include the development, coordination, and monitoring of a student's education plan. Include related paperwork, clerical activities, or staff travel required to perform these activities.

- Providing classroom instruction (including lesson planning).

- Testing, correcting papers.

- Developing, coordinating, and monitoring the Individualized Education Plan (IEP) for a student, which includes ensuring annual reviews of the IEP are conducted, parental sign-offs are obtained, and the actual IEP meetings with the parents.

- Compiling attendance reports.

- Performing activities that are specific to instructional, curriculum, student-focused areas.

- Reviewing the education record for students who are new to the school district.

- Providing general supervision of students (e.g., playground, lunchroom).

- Monitoring student academic achievement.

- Providing individualized instruction (e.g., math concepts) to a special education student.

- Conducting external relations related to school educational issues/matters.

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- Compiling report cards.

- Applying discipline activities.
- Performing clerical activities specific to instructional or curriculum areas.
- Activities related to the immunization requirements for school attendance.
- Performing activities that are specific to instructional, curriculum, student-focused areas.
- Compiling, preparing, and reviewing reports on textbooks or attendance.
- Enrolling new students or obtaining registration information.
- Conferring with students or parents about discipline, academic matters or other school related issues.
- Evaluating curriculum and instructional services, policies, and procedures.
- Participating in or presenting training related to curriculum or instruction (e.g., language arts workshop, computer instruction).
- Translating an academic test for a student.
- Performing clerical activities specific to instructional or curriculum areas.

CODE 4. DIRECT MEDICAL SERVICES - U

School staff should use this code when providing care, treatment, and/or counseling services to an individual in order to correct or ameliorate a specific condition. As noted in the 1997 technical assistance guide, if medical evaluations or assessments are conducted to determine a child's health-related needs for purposes of the IEP development, payment for some or all of the costs may be available under Medicaid as a direct service. This code also includes all related paperwork, clerical activities, or staff travel required to perform these activities. Note, some of the following activities may be subject to the free care principle (discussed in Section V.J. of the Guide).

- Providing health/mental health services contained in an IEP.
- Medical/health assessment and evaluation as part of the development of an IEP.
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports.

- Providing health care/personal aide services.
- Providing speech, occupational, physical and other therapies.
- Administering first aid, or prescribed injection or medication to a student.
- Providing direct clinical/treatment services.
- Performing developmental assessments.
- Providing counseling services to treat health, mental health, or substance abuse conditions.
- Performing routine or mandated child health screens including but not limited to vision, hearing, dental, scoliosis, and EPSDT screens.
- Providing immunizations.
- Targeted Case Management (if provided or covered as a medical service under Medicaid).
- Transportation (if covered as a medical service under Medicaid). See section on claiming for Transportation as an administrative cost.
- Activities which are services or components of services listed in the State's Medicaid plan.

CODE 5.a. TRANSPORTATION FOR NON-MEDICAID SERVICES - U

School district employees should use this code when assisting an individual to obtain transportation to services not covered by Medicaid, or accompanying the individual to services not covered by Medicaid. Include related paperwork, clerical activities or staff travel required to perform these activities.

- Scheduling or arranging transportation to social, vocational, and/or educational programs and activities.

CODE 5.b. TRANSPORTATION-RELATED ACTIVITIES IN SUPPORT OF MEDICAID COVERED SERVICES -PM/50 percent FFP

School district employees should use this code when assisting an individual to obtain

transportation to services covered by Medicaid. This does not include the provision of the actual transportation service, but rather the administrative activities involved providing transportation. This activity also does not include activities which contribute to the actual billing of transportation as a medical service. Nor does it include accompanying the Medicaid-eligible individual to Medicaid services as an administrative activity.

Include related paperwork, clerical activities or staff travel required to perform these activities. See Section V.M. for a more detailed and thorough discussion of Medicaid transportation policy.

- Scheduling or arranging transportation to Medicaid covered services.

CODE 6.a. NON-MEDICAID TRANSLATION - U

This code should be used by school employees who provide translation services related to social, vocational, or educational programs and activities as an activity separate from the activities referenced in other codes. Include related paperwork, clerical activities or staff travel required to perform these activities.

- Arranging for or providing translation services that assist the individual to access and understand non-medical services.

- Arranging for or providing translation services that assist the individual to access and understand non-medical programs and activities.

- Arranging for or providing signing services that assist the individual or family access and understand non-medical programs and activities.

CODE 6.b. TRANSLATION RELATED TO MEDICAID SERVICES -PM/50 percent FFP

Translation may be allowable as an administrative activity, if it is not included and paid for as part of a medical assistance service. However, it must be provided by separate units or by separate employees performing solely translation functions for the school and it must facilitate access to Medicaid covered services.

This code should be used by school employees who provide translation services related to Medicaid covered services as an activity separate from the activities referenced in other codes. Include related paperwork, clerical activities or staff travel required to perform these activities.

- Arranging for or providing translation services that assist the individual to access and understand necessary care or treatment;

- Arranging for or providing signing services that assist the individual or family access and understand necessary care or treatment.

CODE 7.a. PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO NON-MEDICAL SERVICES - U

This code should be used by school staff when performing activities associated with the development of strategies to improve the coordination and delivery of non-medical/non-mental health services to school age children, and when performing collaborative activities with other agencies. Non-medical services may include social, educational, and vocational services. Only employees whose position descriptions include program planning, policy development, and interagency coordination should use this code. Include related paperwork, clerical activities or staff travel required to perform these activities.

- Identifying gaps or duplication of other non-medical services (e.g., social, vocational and educational programs) to school age children and developing strategies to improve the delivery and coordination of these services.

- Developing strategies to assess or increase the capacity of non-medical school programs.

- Monitoring the non-medical delivery systems in schools.

- Developing procedures for tracking families' requests for assistance with non-medical services and the providers of such services.

- Evaluating the need for non-medical services in relation to specific populations or geographic areas.

- Analyzing non-medical data related to a specific program, population, or geographic area.

- Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration around the early identification of non-medical problems.

- Defining the scope of each agency's non-medical service in relation to the other.

- Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services to the school populations.

- Developing non-medical referral sources.

- Coordinating with interagency committees to identify, promote and develop non-medical services in the school system.

CODE 7.b. PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO MEDICAL SERVICES -PM/50 percent FFP

This code should be used by school staff when performing activities associated with the development of strategies to improve the coordination and delivery of Medicaid coverable medical/mental health services to school age children, and when performing collaborative activities with other agencies. Only employees whose position descriptions include program planning, policy development, and interagency coordination should use this code. Include related paperwork, clerical activities or staff travel required to perform these activities.

- Identifying gaps or duplication of medical/mental services to school age children and developing strategies to improve the delivery and coordination of these services.

- Developing strategies to assess or increase the capacity of school medical/mental health programs.

- Monitoring the medical/mental health delivery systems in schools.

- Developing procedures for tracking families' requests for assistance with Medicaid services and providers. (This does not include the actual tracking of requests for Medicaid services.)

- Evaluating the need for Medicaid services in relation to specific populations or geographic areas.

- Analyzing Medicaid data related to a specific program, population, or geographic area.

- Working with other agencies providing Medicaid services to improve the coordination and delivery of services, to expand access to specific populations of Medicaid eligibles, and to improve collaboration around the early identification of medical problems.

- Defining the scope of each agency's Medicaid service in relation to the other.

- Working with Medicaid resources, such as the managed care plans, to make good faith efforts to locate and develop EPSDT health services referral relationships.

- Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services to the school populations.

- Developing medical referral sources such as directories of Medicaid providers and managed care plans, who will provide services to targeted population groups, e.g., EPSDT children.

- Coordinating with interagency committees to identify, promote and develop EPSDT services in the school system.

CODE 8.a. NON-MEDICAID TRAINING - U

This code should be used by school staff when coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefit of the programs other than the Medicaid program such as educational programs; for example, how to assist families to access the services of the relevant programs, and how to more effectively refer students for those services. Include related paperwork, clerical activities, or staff travel required to perform these activities.

Training can be coded in three ways: As a separate code (Code 8.a.); as General Administration (Code 10); or as part of a specific activity code. If claimed as part of a specific activity code, the State should add a relevant bullet to the applicable code.

- Participating in or coordinating training which improves the delivery of services for programs other than Medicaid.

- Participating in or coordinating training which enhances IDEA child find programs.

CODE 8.b. MEDICAID SPECIFIC TRAINING -PM/50 percent FFP

This code should be used by school staff when coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefit of the Medicaid program, how to assist families to access Medicaid services, and how to more effectively refer students for services. Include related paperwork, clerical activities, or staff travel required to perform these activities.

Training can be coded in three ways: As a separate code (Code 8.b.); as General Administration

(Code 10); or as part of a specific activity code. If claimed as part of a specific activity code, the State should add a relevant bullet to the applicable code.

- Participating in or coordinating training which improves the delivery of Medicaid services.

- Participating in or coordinating training which enhances early identification, intervention, screening and referral of students with special health needs to EPSDT services (This is distinguished from IDEA child find programs.)

CODE 9.a. REFERRAL, COORDINATION, AND MONITORING OF NON-MEDICAID SERVICES - U

School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of non-medical, such as educational services.

- Making referrals for and coordinating access to social and educational services such as child care, employment, job training, and housing.

- Making referrals for, coordinating, and/or monitoring the delivery of State education agency mandated child health screens (vision, hearing, scoliosis).

- Making referrals for, coordinating, and monitoring the delivery of scholastic, vocational, and other non-health related examinations.

- Gathering any information that may be required in advance of these non-Medicaid related referrals.

- Participating in a meeting/discussion to coordinate or review a student's need for scholastic, vocational, and non-health related services not covered by Medicaid.

- Monitoring and evaluating the non-medical components of the individualized plan as appropriate.

Case Management. Note that case management as an administrative activity involves the facilitation of access and coordination of program services. Such activities may be provided under the term Case Management or may also be referred to as Referral, Coordination, and Monitoring of non-Medicaid Services.

Case management may also be provided as an integral part of the service and would be included in the service cost.

School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of NON-Medicaid covered services. Include related paperwork, clerical activities or staff travel required to perform these activities.

CODE 9.b. REFERRAL, COORDINATION, AND MONITORING OF MEDICAID SERVICES -PM/50 percent FFP

School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of medical (Medicaid covered) services. Activities that are part of a direct service are not claimable as an administrative service. Include related paperwork, clerical activities, or staff travel necessary to perform these activities.

- Identifying and referring adolescents who may be in need of Medicaid family planning services.
- Making referrals for and/or coordinating medical or physical examinations and necessary medical/mental health evaluations.
- Making referrals for and/or scheduling EPSDT screens, interperiodic screens, and appropriate immunization, but NOT to include the State-mandated health services.
- Referring students for necessary medical health, mental health, or substance abuse services covered by Medicaid.
- Arranging for any Medicaid covered medical/mental health diagnostic or treatment services which may be required as the result of a specifically identified medical/mental health condition based on the findings other then when provided as a direct service.
- Gathering any information that may be required in advance of these referrals.
- Participating in a meeting/discussion to coordinate or review a student's needs for health-related services covered by Medicaid.
- Providing follow-up contact to ensure that a child has received the prescribed medical/mental health services.
- Coordinating the completion of the prescribed services, termination of services, and the referral of the child to other Medicaid service providers as may be required to provide continuity of care.
- Providing information to other staff on the child's related medical/mental health

services and plans.

- Coordinating the delivery of community-based medical/mental health services for a child with special/severe health care needs.

- Providing information about Medicaid EPSDT screening (e.g., dental, vision) in the schools that will help identify medical conditions that can be corrected or improved by services through Medicaid.

- Monitoring and evaluating the Medicaid service components of the IEP as appropriate.

- Coordinating medical/mental health service provision with managed care plans as appropriate.

Case Management. Note that case management as an administrative activity involves the facilitation of access and coordination of services which are covered under the State's Medicaid program. Such activities may be provided under the term Administrative Case Management or may also be referred to as Referral, Coordination, and Monitoring of Medicaid Services.

Case management may also be provided as an integral part of a medical service and would be included in the service cost. The State may also cover targeted case management as an optional service under Medicaid.

School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of Medicaid covered services. Include related paperwork, clerical activities or staff travel required to perform these activities.

CODE 10. GENERAL ADMINISTRATION - R

This code should be used by time study participants when performing activities that are not directly assignable to program activities. Include related paperwork, clerical activities, or staff travel required to perform these activities. Note that certain functions, such as payroll, maintaining inventories, developing budgets, executive direction, etc., are considered overhead and, therefore, are only allowable through the application of an approved indirect cost rate.

Below are typical examples of general administrative activities, but they are not all inclusive.

- Taking lunch, breaks, leave, or time not at work.

- Establishing goals and objectives of health-related programs as part of the school's

annual or multi-year plan.

- Reviewing school or district procedures and rules.
- Attending or facilitating school or unit staff meetings, training, or board meetings.
- Performing administrative or clerical activities related to general building or district functions or operations.
- Providing general supervision of staff, including supervision of student teachers or classroom volunteers, and evaluation of employee performance.
- Reviewing technical literature and research articles.
- Other general administrative activities of a similar nature as listed above which cannot be specifically identified under other activity codes.

V. CLAIMING ISSUES

A. Documentation

The time study methodology and instructions, as well as the cost allocation requirements issued by the State Medicaid Agency to the schools, must stipulate the documentation the schools must maintain to support the claims submitted to the State. The documentation for administrative activities must clearly demonstrate that the activities are provided to Medicaid applicants or eligibles, and are connected with application assistance and the gathering of documentation for a complete eligibility determination or for administering services covered under the State Plan. In accordance with the statute, the regulations, and the State Plan, the State is required to retain adequate source documentation to support the Medicaid payments for administrative claiming. See §1902(a)(4) of the Act and 42 CFR 431.17; see also 45 CFR 74.53 and 42 CFR 433.32(a) (requiring source documentation to support accounting records) and 45 CFR 74.20 and 42 CFR 433.32(b and c) (retention period for records). The administrative claiming records must be made available for review by State and Federal staff upon request during normal working hours (§1902(a)(4) of the Social Security Act, implemented at 42 CFR 431.17).

Additional guidance regarding documentation for compensation of salary and wages is found in OMB Circular A-87, Attachment B, Section 11.h.(5):

> Personnel activity reports or equivalent documentation must meet the following standards:
>
> > (a) They must reflect an after-the-fact distribution [i.e., distribution following completion of the activity] of the actual activity of each employee,

(b) They must account for the total activity for which each employee is compensated,

(c) They must be prepared at least monthly and must coincide with one or more pay periods, and

(d) They must be signed by the employee as being a true statement of activities and the employee/office will retain documentation to support the report.

Other principles related to documentation and documentation requirements that apply in addition to the above requirements are:

- Salaries and wages, including personnel activity reports;
- Accounting records should be supported by source documentation such as canceled checks, paid bills, payrolls, contract and subgrant award documents;
- Foster care payments and administrative costs ;
- Case management services based on time studies are an acceptable form of documentation for a given period; ;
- Costs must be verified as being incurred in a particular Federal program;
- Undocumented personnel costs are not allowed; and
- Adequate documentation for labor costs is required.

B. Sampling/Time Studies

Recognizing the necessity of using a sample to develop administrative claims, OMB Circular A-87 permits the use of "substitute systems" for allocating salaries and wages to Federal awards to be used in place of activity reports when employees work on multiple activities or cost objectives. Any such system must be approved by the funding agency. These sampling systems (or time studies) may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort or outcomes. For time studies, all activities need to be sampled even if they are not strictly related to Medicaid. A summary of the relevant sections of OMB Circular A-87 follows:

- Attachment A, Section A.1: Each awarding grant bears its fair share of costs; C, Basic Guidelines, 1.h: Not included as match for another Federal program. 1. J: Be adequately documented. 3.c: Costs cannot be shifted from one grant to another to avoid restrictions.

- Attachment B, Selected Items of Cost, 11. Compensation for personnel services, h (1-4): Standards for payroll documentation. (6) Substitute Systems are: subject to approval; include random moment sampling or other quantifiable measures; (a) must meet acceptable statistical sampling standards including (I) include all salaries of employees to be allocated, (ii) the entire time period involved must be covered; (c) less than full compliance with statistical sampling standards may be accepted by the agency if it concludes that the proposal will result in lower costs to Federal awards than the compliant

system.

The major issues involved in time studies include the following: development and approval of the activity codes to be used (discussed in Section IV of this Guide), the participants to be sampled, the sampling plan, statistical validity (95 percent confidence level or higher), documentation, training for staff in the sample universe, and monitoring. The following subsections discuss those issues in greater detail:

1. Sample Universe

A basic step in the approval of a time study is the determination of the sample universe, i.e., the LEA staff person(s) who will participate (be sampled under) the time study. Although Medicaid administrative activities may be performed by LEA staff who provide direct medical services (for example, nurses and physical therapists and educational staff, such as the Director of Exceptional Student Education and teachers aides), only those staff whose costs are not met by other funding sources may be included in the sample universe. For example, if 100 percent of the costs of social workers were met by Federal funding sources or third party payers other than Medicaid, then there would be no reason to include such workers in the time study and they must be excluded from participation. Furthermore, the costs of such workers should not be included in the costs.

It may also be appropriate to exclude other workers from the study. For example, there may be medical providers in a school who furnish services to students under contract and are paid on a fixed fee per test (for example, audiologists paid a set amount for each hearing test performed) and they do not perform any other activities that would be claimable. Such workers should not be included in the sample universe provided their costs are excluded from the base to be allocated.

Costs allocated to the Medicaid program should be offset by other funding sources. LEA staff whose salary costs are not entirely met by one or more Federal grants may be eligible to be included in the sample. Thus, if funds from an educational grant pay only a percentage of the individual's costs, that person can be sampled as long as the costs are offset by the funds from the educational grant. Also to be excluded are any matching funds required by the educational grant. In addition, staff members such as physical therapy aides need to be included in the sample universe and not simply allocated based on the activities of professionals (e.g., physical therapists).

2. Sampling Plan Methodology

OMB Circular A-87 states that, with regard to sampling:

> "Substitute systems for allocating salaries and wages to Federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limited to,

> random moment sampling, case counts, or other quantifiable measures of employee effort."

As indicated, one of the most commonly used sampling methodologies for time studies is random moment samples (RMS). For the reasons that follow, the RMS method represents an acceptable method for accurately assessing the time spent on administrative activities.

RMS covers the entire sampled period, such as a quarter, but does not include weeks when schools are not in session. The sampling universe must include all employees whose salaries are to be allocated. According to OMB Circular A-87, "The entire time period involved must be covered by the sample; and the results must be statistically valid and applied to the period being sampled." The circular also indicates that time reports be completed at least monthly. RMS meets these requirements. OMB Circular A-87 does provide that a less than fully compliant sample can be used if the cognizant agency can demonstrate that the proposed system "will result in lower costs to Federal awards than a system that complies with the standards."

3. Time Study Documentation

As with all administrative costs that are related to time study activities, there must be documentation of the costs that will be claimed for reimbursement. Documentation to be retained must support and include the following: the sample universe determination, sample selection, sample results, sampling forms, cost data for each school district, and summary sheets showing how each school district's claim was compiled. All claims by the LEAs and schools are summarized and submitted to the State Agency for one payment. The individual sample sheets may or may not be kept locally. Sometimes individual sheets are maintained locally while summary records are maintained at a central location.

Note that if a portion of a sampled employee's time is also billed as medical services, then the administrative time study results should be validated in part by comparing the time coded to direct medical services (Code 4) to the actual amount of hours billed directly. The results should be within a reasonable tolerance or else the time study may result in an effective double payment.

4. Training for Staffing Time Study

All staff in the sample universe should be trained before the sampling begins. Training should cover all aspects of the sampling process. Staff should be clear on how to complete the form, how to choose activities, the difference between health related and other activities, and where to obtain technical assistance if there are questions. Professional staff must be clear on how to determine when and if their professional knowledge was required to do a function/activity. Further, to assure consistent application, a schedule of training on sampling and on the approved activity codes to be used by the staff who are sampled should be applied. This schedule should show the training required of the sample takers, staff being sampled, and frequency of training. The frequency of training should take into account turnover at the local level.

5. Monitoring Process

In order to ensure that the time study is statistically valid (for example, at the 95 percent confidence level), the State Medicaid Agency must monitor the compliance of the LEAs to the requirements of the sampling methodology. A description should be included of the monitoring of the sample results. This description should include information on the frequency of reviews at the local level, staff performing the reviews, and the review protocol.

C. Offset of Revenues

The costs which need to be allocated must be offset by certain revenues in order to reduce the total amount of costs in which the Federal government will participate. To the extent the funding sources have paid or would pay for the costs at issue, Federal Medicaid funding is not available and the costs must be removed from total costs (See OMB Circular A-87, Attachment A, Part C., Item 4.a.). The following include some of the revenue offset categories which must be applied in developing the net costs:

- All Federal funds, along with maintenance of effort and other State/local matching funds required by the Federal grant.

- All State expenditures which have been previously matched by the Federal government (includes Medicaid funds for medical assistance (e.g., fee-for-service funds).

- State funds, specifically targeted or earmarked for the delivery of program services (such as medical assistance), must be used for the purposes for which they are targeted or earmarked and cannot be used to match other expenditures; for example, the costs of administrative activities. These funds must be offset in developing net costs.

- Insurance and other fees collected from non-governmental sources must be offset against claims for Medicaid funds.

- A program may not claim any Federal match for administrative activities if its total cost has already been paid by the revenue sources above. A government program may not be reimbursed in excess of its actual costs, i.e., make a profit.

D. Cost Allocation

Requirements for the development, documentation, submission, negotiation, and approval of public assistance cost allocation plans are set forth in Subpart E of 45 CFR Part 95 and ASMB C-10. All administrative costs (direct and indirect) are normally charged to Federal awards by implementing the public assistance cost allocation plan (CAP). OMB Circular A-87, Cost

Principles for State, Local and Indian Tribal Governments - Attachment D - extends these requirements to all Federal agencies whose programs - including Medicaid - are administered by a State public assistance agency. OMB Circular A-87 policy is that State public assistance agencies will develop, document and implement, and the Federal government will review, negotiate, and approve, public assistance CAPs .

In accordance with the Federal regulations indicated above and OMB Circular A-87, a public assistance CAP must be amended and approved by the Division of Cost Allocation (DCA) within DHHS before FFP would be available for administrative claims in the Medicaid program. In this regard, the public assistance CAP must provide, in accordance with the approved interagency agreements, for reimbursement of the administrative activities performed in the school setting and for which claims will be made by the LEAs, school districts, and schools to the State Medicaid Agency. The public assistance CAP must make explicit reference to the methodologies, claiming mechanisms, interagency agreements, and other relevant issues that will be used by the LEAs, school districts, and schools for making such claims and appropriately allocating costs. HCFA does not have direct authority for approval of the public assistance CAPs; that is the purview of the DCA. However, HCFA works directly with the DCA in the public assistance CAP review and approval process; under this process, the DCA will not approve such public assistance CAPs without HCFA's review and approval of the methodologies referenced in the public assistance CAP. Therefore, the referenced elements must be reviewed and approved by HCFA before implementation of the school-based administrative claiming program and before the claiming of FFP.

See also Principle 12 in Section IV. of the Guide, “Review and Approval of Programs and Codes by HCFA.”

Furthermore, the school-based administrative claiming program must be supported by a system which has the capability to isolate the costs which are directly related to the support of the Medicaid program from all other costs incurred by the school and which will ultimately be claimed by the State Medicaid Agency as administration. Such costs must comply with the cost allocation principles described in OMB Circular A-87 which requires that costs be “necessary and reasonable” and “allocable” to the Medicaid program. Claims for the school’s or LEA’s indirect costs are only allowable when the entity has an approved indirect cost rate issued by the cognizant agency and costs are claimed in accordance with the rate.

E. Administrative Claiming Implementation Plan

As discussed in the preceding section, the public assistance CAP amendments must be reviewed and approved by the DCA and HCFA. To ensure the successful implementation of a State Medicaid program to pay for Medicaid-related administrative claiming activities in schools, and to support and expedite the public assistance CAP and underlying claims mechanism approval process, we strongly suggest that the State Medicaid Agency submit an “administrative claiming implementation plan” (the “implementation plan”) which provides a comprehensive description of

the mechanism and process for claiming administrative costs under Medicaid. To the extent the implementation plan provides underlying support and documentation referenced in the public assistance CAP amendments, it must be acceptable to HCFA before FFP will be available.

The following elements should be included in the implementation plan:

- **Interagency Agreements.** The State Medicaid Agency must have an interagency agreement with the State Department of Education or separate agreements with participating school districts for Title XIX (Medicaid) or in accordance with OMB Circular A-87, Attachment A. These interagency agreements should list or reference the allowable administrative activities for which school districts will be reimbursed and certify that all claims will be in accordance with A-87, the State Medicaid Plan and all Federally approved public assistance CAPs . As appropriate, the interagency agreement would describe or reference the treatment of indirect costs. The requirements for interagency agreements are also discussed in Section III of this Guide.

- **Description of Current Administrative Activities Paid by Medicaid.** Other State and local agencies (e.g., State and local health departments and mental health authorities) may be performing and receiving Federal reimbursement for the same services which are being considered for reimbursement in the school setting. Similarly, Medicaid managed care plans may be providing the same services to school aged children. Federal regulations prohibit duplicate payments for the same service. Therefore, the State should provide a description of the current administrative activities of these other entities. This would include a description of the relationship of these activities to Medicaid in the schools. A chart or matrix could be used to show the activities for which each agency currently receives Federal reimbursement and how this will change when schools are reimbursed for performing administrative activities.

- **Treatment of Indirect Costs.** In its submission of the administrative claiming implementation plan, the State Medicaid Agency must indicate whether indirect costs will be claimed. NOTE, indirect costs can only be claimed if there is an indirect cost rate approved by the cognizant agency responsible for approving such rates. With respect to school-based administrative costs, the cognizant agency is the Federal Department of Education or its delegate. Where indirect costs are allowed, the LEA, school district, or school must certify that costs claimed as direct costs do not duplicate those costs reimbursed through application of the indirect cost rate.

- **Sampling /Time Study Plan.** As discussed in greater detail in Section V.B., the time study methodology used to sample costs must be approved and statistically valid. The time study must include a description of job classifications to be sampled, job classifications considered eligible and ineligible for reimbursement and a listing of allowable activities performed by employees considered eligible for reimbursement. This plan should also address how your Agency will assure that results from the sampling

methods will be in the 95 percent confidence level.

Further, to assure consistent application, the plan must also include a schedule of training on sampling and on the approved activity codes to be used by the staff who are sampled. This schedule should show the training required of the sample takers, staff being sampled, and frequency of training. In some States, training to both sample takers and those sampled is done quarterly (before each sample is conducted) to assure consistency. This is needed because of turnover on the local level.

- **Monitoring Process.** Include a description of your monitoring of the sample results. This description should include information on the frequency of reviews at the local level, staff performing the reviews, and the review protocol that will be followed.

- **Review of Implementation Plan By HCFA.** The implementation plan should be submitted to HCFA prior to submittal of the public assistance CAP amendment to DCA.

- **Certified Public Expenditures.** If the administrative payments for school-based services will be made utilizing certified public expenditures (CPE) to satisfy the State match, include in the implementation plan a description of the process used to document that there are sufficient State funds available to match Title XIX funds. A description of the process should be provided that will be used to verify/certify that local education agencies have unrestricted State funds available to earn the Federal participation claimed (i.e., that funds are not already being used to match Federal funds of other Federal programs or otherwise reimbursed by other Federal grants).

F. Timely Filing Requirements

Section 1132(a) of the Act requires that a claim by a State for FFP with respect to an expenditure made during any calendar quarter must be filed within the two-year period which begins on the first day of the calendar quarter immediately following such quarter. This section also provides that no payment shall be made for expenditures not claimed within this period.

The implementing regulations for timely filing requirement are at 45 CFR Part 95 Subpart A and provide specific guidelines for determining when an expenditure is said to have been made so as to trigger the two-year filing period (46 Fed. Reg. 3529 January 15, 1981). A State's expenditure for Medicaid services is considered to have been made "in the quarter in which any State agency made a payment to a service provider."

Federal regulations at 45 CFR 95.13 (d) state: "We consider a State agency's expenditure for administration or training ... to have been made in the quarter payment was made by a State agency to a private agency or individual;…"

Further, 45 CFR 95.4 states: "State agency for purposes of expenditures for title XIX, means any

agency of the State, including the State Medicaid Agency, its fiscal agents, a State health agency, or any other State or local organization which incurs matchable expenses;"

G. State Law Requirements

The OMB Circular A-87 states in item 1.c. of Attachment A, "General Principles for Determining Allowable Costs," Section C, Basic Guidelines: "To be allowable under Federal grants, cost must meet the following criteria . . . . be authorized or not prohibited under State or local laws and regulations." Thus, FFP for school-based services and administrative outreach claims is not available if the State is not in compliance with its own statutes. A question of State law may surface during a review of State practices or be brought to light by other means; however, it is not expected that an exhaustive review of all State laws be conducted. If there is a question of whether the State agency is in violation of State law, a legal opinion should be sought, preferably from the State Attorney General.

H. Contingency Fees

Many school districts or local education authorities have chosen to use the services of consultants. The OMB Circular A-87 states in item 33.a, of Attachment B, "Selected Items of Costs," that:

> Cost of professional and consultant services rendered by persons or organizations that are members of a particular profession or possess a special skill, whether or not officers or employees of the governmental unit, are allowable, subject to section 14 when reasonable in relation to the services rendered **and when not contingent upon recovery of the costs from the Federal Government** (added emphasis).

Thus, if payments to consultants by schools are contingent upon payment by Medicaid, the consultant fees are not an allowable cost of services rendered and as such, may not be used in determining the payment rate of school-based services. Further, as discussed in Office of Inspector General (OIG) Chief Counsel Advisory Opinion Number 98-4, contractual arrangements with consultants based on percentage billing arrangements may increase the risk of upcoding and similar abusive billing practices. Although this is not a per se application, the opinion suggests the need for caution in using such arrangements to avoid prohibited payments under the anti-kick back statute, Section 1128(b) of the Act.

Note also that OMB Circular A-87 states in item C.1., of Attachment A, "General Principles for Determining Allowable Costs," that to be allowable, costs must be authorized or not prohibited under State or local laws or regulations.

I. Provider Agreements

There must be a provider agreement between the State and the actual provider of services

(Sections 1902(a)(4), 1902(a)(27), 1902(a)(57) and 1902(58) of the Social Security Act (SSA) implemented at 42 CFR 431.107).

J. Third Party Liability (TPL)/Medicaid as payor of last resort/Free Care

The Medicaid program is generally the "payor of last resort." This refers to the principle that Medicaid must pay for services and the costs of activities only after other programs or third parties (such as private insurance) have paid for such services or costs of activities. This principle is based in Medicaid statute under two provisions, third party liability (TPL) and those relating to the consideration of individual's income and resources in determining Medicaid eligibility. The TPL provisions require the State Medicaid Agency to take all reasonable measures to ascertain the legal liability of all potential third parties for paying for care and services covered under the State's Medicaid plan. Furthermore, the State is required to seek such payment by the third parties before making payment under Medicaid and also to seek such payment as a recovery after making payment under the Medicaid program. Additionally, Medicaid statute is explicit in requiring the State Medicaid Agency to consider income and resources in determining an individual's eligibility.

An exception or qualification to this principle, contained at Section 1903(c) of the Act, relates to medical services contained in a child's Individualized Education Plan (IEP). If such services are contained in a child's IEP, the child is eligible for Medicaid, and the services are covered by the Medicaid program, then Medicaid may pay for such services. Another qualification is contained at Section 1902(a)(11) of the Act, under which Medicaid can pay for the allowable care and services that may be reimbursed under title V of the Act (Maternal and Child Health Services block grant) before title V.

Therefore, except for special circumstances, the State Medicaid Agency is the payor of last resort for the costs of services and activities that are also payable under other programs or by third parties. Furthermore, Medicaid does not pay for the health services or administration costs related to those services that are provided free of charge to non-Medicaid eligible students. In applying the free care principle to determine whether medical services are provided free of charge and, thus, there is no payment liability to Medicaid, a determination must be made whether both Medicaid and non-Medicaid beneficiaries are charged for the service.

The free care principle is relevant to the construction of time study activity codes and reporting under such codes by time study participants as relates to activities that are subject to payment by other programs. Thus, for example, if certain activities or services are specifically provided for under a special program, the cost of such administrative activities related to such programs would not be allowable as administrative costs in Medicaid. For example, State laws may require immunizations be provided to all school children, regardless of whether the child is Medicaid eligible or the child's income status. In such a case the administrative activities related to assisting the child to obtain such immunizations in the school would not be reimbursable as a Medicaid administrative cost. Therefore, such an activity would be reported under Code 9.a., not 9.b.,

below.

K. Transportation as Administration

HCFA's policy concerning Medicaid payment for transporting Medicaid-eligible IDEA children to and from schools is described in the Medicaid and School Health Technical Assistance Guide, issued in 1997. That Guide indicates that transportation to and from school may be claimed as a Medicaid service when the child receives a medical service in school on a particular day and when transportation is specifically listed in the IEP as a required service. As a Medicaid administrative activity, Codes 5.a. and 5.b. cover the time spent in assisting or actually transporting a child to a service, but does not cover the actual cost of the transportation (bus fare, taxi fare, etc.).

An IEP should include only specialized services that a child would not otherwise receive in the course of attending school. Therefore, a child with special education needs under IDEA who rides the regular school bus to school with the other non-disabled children in his/her neighborhood should not have transportation listed in his IEP and the cost of that bus ride should not be billed to Medicaid.

If a child requires transportation in a vehicle adapted to serve the needs of the disabled, including a specially adapted school bus, that transportation may be billed to Medicaid if the need for that specialized transportation is identified in the IEP. In addition, if a child resides in an area that does not have school bus transportation (such as those areas in close proximity to a school) but has a medical need for transportation that is noted in the IEP, that transportation may also be billed to Medicaid. As always, transportation from the school to a provider in the community also may be billed to Medicaid. These policies apply whether the State is claiming FFP for transportation under Medicaid as medical assistance or administration.

When a State claims FFP under the Medicaid program for transportation services as medical assistance under an approved reimbursement rate, the requirements for documentation of each service must be maintained for purposes of an audit trail. This usually takes the form of a trip log maintained by the provider of the specialized transportation service. The methodology used to establish the transportation rate should also be described in the State plan.

When FFP for the costs of transportation services is claimed as administration, the requirements of the OMB Circular A-87 for determining allowable costs, as well as any other applicable requirements for claiming administration under Medicaid, must be met. This includes the development of a cost allocation methodology to ensure that Medicaid only pays for that portion of the specialized mode of transportation allocable to Medicaid beneficiaries.